Ellen Kelsay

What do telehealth, social determinants of health, and preventive care have in common? For better or worse, all have been thrust into the national spotlight due to the coronavirus pandemic, and they share this attention for good reason, as each has a potential to enable better health. Perhaps no one is more passionate about the topic of better health through better health care than my guest today, Peggy O'Kane, the founder and president of the National Committee for Quality Assurance, otherwise known as NCQA. Peggy started NCQ more than 30 years ago working by herself in a borrowed office. Since those days the organization has grown considerably, and Peggy has been named one of the most influential people in health care, many times over, due to her unwavering commitment to improving health care using measurement, transparency, and accountability. I'm Ellen Kelsay, and this is a Business Group on Health podcast, conversations with experts on the most relevant health and well-being issues facing employers today. During this episode, I asked Peggy why telehealth, social determinants, and preventative care are on her radar and why it's important to focus on them through the lens of quality access and equity.

Peggy, welcome. Thank you for joining me today.

Peggy O’Kane:

Thank you, Ellen. I'm delighted to be here.

Ellen Kelsay:

Great. Well, let's dive right in. You've spent the majority of your career focused on issues related to quality. I'd like to start our conversation by asking you about your perspective on the impact of COVID on the pillars of quality. Can you tell us some more about that?

Peggy O’Kane:

Boy, that's a big question. Well, let's just start with what happened in March. The country shut down. People were alone in their homes. They were afraid to go out. And that included going to the doctors, going to the emergency room, or to the hospital. And so effectively people stopped using health care. And, for some people, healthy people, health care can be delayed without any bad outcomes, but for people with chronic conditions or people who, you know, have very serious illnesses, health care is literally lifesaving. So there was a lot of scrambling to try to make sure that people got care when they needed it; and they didn't always, so let's be clear about that. One of the things that happened is CMS, and for very good reasons that I fully understand, said we collect data for Medicare Advantage plans, which get paid according to their quality. And because things were in such an uproar, CMS announced that it wouldn't be collecting any quality data for this measurement year.

Now this is actually looking back at 2019, but that's what happened. And so I think a signal was sent that quality is kind of optional and that's something that I'm very concerned about. So second point, we know that we have inequities in health care and in health outcomes. And we know the people of color, in particular, and people who are in essential professions or jobs are more vulnerable. Partly that was because they were more exposed to the coronavirus, but partly it's because many times they live in conditions that are not particularly healthy, where it's crowded. They live in polluted parts of the country, and that seems to be associated, although not proven, with more bad outcomes of COVID. It

was ironic because we know the incidence and the prevalence of product conditions are much higher among these kind of low-paid, essential workers.

We have this combination of nobody's getting health care; preventive services were completely suspended, so that meant people weren't getting their shots, and children, in particular, the utilization from data that we've seen from a company that supports pediatric practices, pediatric visits dropped by 71%. There were some televisits happening, but you know you can't give immunizations by phone or by video. There are big holes in the coverage of preventive services since that time, which I think at the moment, plans at least are trying to catch up and a lot of provider organizations as well.

We kind of had a halt to preventive services; we had a halt to chronic disease management, and we had people afraid to go to the doctors. So that was a formula for really disaster, but we were fortunate to have this technology called telehealth in the background. And there have been people who have been trying for decades to get practitioners to use it, to get patients to use it. All of a sudden there it was; it was the only option, and so people did. It turns out many people really like it. For systems that were set up, the doctor could sit in their home or in their office and do televisits and be connected to their electronic medical records and the patient's record. It actually worked really well for a lot of things. It doesn't work for every kind of situation, but we're within view of situations where it can even work for monitoring of people with chronic conditions, and so forth.

There was this rush into telehealth and CMS, which had been very restrictive about telehealth, was very worried that people would overuse it or abuse it, and private payers as well. Everybody lifted the restrictions because it was the only way to get health care to people. And speaking of social determinants, I know some of the plans had doctors actually just calling patients in their plans and saying, how are you doing? They said that the biggest issue was people weren't able to get food. So all of a sudden here was the health plan trying to bridge these important needs people had that weren't necessarily health care needs. It was quite a moment of learning and somewhat chaotic in the rollout, but it actually was a lifeline for both patients and for systems.

Ellen Kelsay:

There's so much there that I want to dive into and you described early in your comments there about what could be almost a perfect storm of factors that could be almost disastrous on quality, but yet kind of the shining light in the middle of all of that is the lifeline of telehealth that you just referred to. And I know that that has been a significant area of focus for you all at NCQA. You stood up a task force on telehealth policy and just recently released a report. So what are some of the key findings and recommendations coming out of that group's work?

Peggy O’Kane:

First of all, let me back up and talk about some of the restrictions that existed. First of all, payment levels for telehealth visits were very, very low, like $15 a visit. Practitioners were not interested in doing a visit for $15, especially because it's not necessarily easier to do a telehealth visit, especially if people aren't used to it. So there was that, then there were restrictions on who could do the telehealth visit and CMS had a rule that the patient had to have an existing relationship with the practice in order to have telehealth be paid for. Many patients don't even have a usual source of care, so that was a big deterrent. Many states have laws that people couldn't practice to cross state lines. There were lots of regulatory barriers and they were all taken down under this public health emergency that was declared around COVID, and states as well, and private payers as well.

We are at this point now where we're forming this task force. What needs to go back into place in order to make sure telehealth doesn't get abused as people had been worried about it in the first place. Basically, the task force, which included policy people, providers of care, payers, telehealth providers, platform people and practitioners, consumer representatives. We had AARP there. We tried to come to consensus on what should be done. Oh, by the way, also privacy, HIPAA was suspended for telehealth. I think there was general consensus that these barriers should be removed, but then the HIPAA, the privacy part, should be reinstated as quickly as possible because people view that as something that will cause a lack of trust in telehealth and a reluctance on the part of patients to use it.

I think for payers, the big worry is people are going to just go out there and turn the crank on telehealth visits and a lot of unnecessary visits will be billed for. We didn't see that in the COVID panic and the high points of the pandemic, but to be fair, we can't really generalize from a period like that because remember people weren't going out to go get health care. There was no way that it was going to generate extra utilization of specialty care or hospital care or send people to the EDS. We have some data from the period, but what we have to do now is understand what happens during normal times, or sort of as normal as they are right now, which is not a hundred percent, but it isn't as bad as it was.

Ellen Kelsay:

Well, the report is impressive. There's so much great work that went into that, and it's certainly a great multi-stakeholder effort throughout, lots of great recommendations, and as you said, important considerations as we move forward. One of them, and it is related to perhaps some of the underserved populations, is relating to how do we make sure that telehealth is accessible and truly accessible to all populations. Did the report contemplate that at all or how do you all perhaps organizationally?

Peggy O'Kane:

Yes, that was a heavy point of discussion. I think people know that we have parts of this country, including in some urban areas where people do not have access to broadband. And so I think there was a general consensus that there should be some kind of governmental intervention to make sure that broadband is both available in the area and affordable for the people who need it. There was no debate about that. I think going back to costs, there was a lot of lively debate around costs. There was a faction that felt that there should be parody of payment for a telehealth visit versus an in-person visit. That was not one of the recommendations, because sometimes you can't do the same things in a telehealth visit that you can do in an in-person visit.

We know that often in-person visits are accompanied by a telephone call to say your lab results are normal. There was general feeling that that kind of thing should not be billed as a separate visit. There was a lot of back and forth about how to pay for it. I think for me, and I'm an advocate of population health models and value-based payment, it's so much easier to think about this in a value-based payment context, because when you have a system that's trying to manage for really good outcomes, including lower costs, or at least not higher costs, they will be very judicious about how they use the telehealth. I think what I said, and this never made it into the report, is that you can expect payers are going to set a lot of rules around payment for the fee for service context because they want to make sure that this doesn't result in some financial bleeding on the part of a bill payer.

In general, I think the real tremendous potential of telehealth, which is unlocking the door to all kinds of virtual care models is, if it's integrated, if it is used as a tool by the system. So if I need to come in, I'm going to be asked to come in. If I can manage it by phone and that's my preference, that's how it will get

done. There is a kind of beauty of trying to live within a budget and do your best to deliver high-quality care within a budget, which is what value-based payment is.

Ellen Kelsay:

I'm so glad you mentioned that as well as the point on data integration and coordination and certainly the expectations as well as requirements that virtual care providers can practice and deliver care both in a value-based way with outcomes and that it is integrated into the overall care that a patient may be receiving and not as a standalone adjunct to the rest of their care delivery through perhaps traditional brick and mortar office visits. I think that point you raised is very, very important.

Peggy O'Kane:

I think if you just step back from the situation, so we had this emergency, we saw what happened, it was a lifeline, but now is the opportunity to start designing and curating telehealth and integrating it into the system really to prove what the real potential is, which I think none of us really understands very well at the moment. We can only imagine.

Ellen Kelsay:

I agree. It will be interesting to keep our eyes on that collectively in the months and years ahead.

Peggy O'Kane:

And we hope that there's an opportunity for a lot of shared learning. It's very painful to watch people reinventing the wheel. We see it all the time in the data and electronic medical records struggles and so forth. You see lessons having to be learned over and over again, or not learned, that's even worse, and bad things happening. If ever there was a moment for shared learning and shared design, this is it. I hope people will rise to the occasion.

Ellen Kelsay:

Here's to that…agree. Your organization does clearly so much work across a number of different categories, but you really have a paramount focus around quality and health care. And quality, as we think about a landscape where virtual modalities are becoming more and more important, and as you said hopefully a lot of shared learnings as we move forward around this modality of virtual care delivery across a number of specialties, not just primary care telehealth, but a lot of specialties are delivering care virtually. Do you all think that the quality measures that have historically been applied to in-person delivery of services are the same that will be needed in a virtual delivery fashion? Or perhaps, will they be nuanced and need to evolve to account for virtual care service delivery?

Peggy O'Kane:

I think that there are unique issues that emerge in telehealth. How did it go for the patient? What was that experience like? We do want to know those sort of telehealth specific concerns. If I have a patient with multiple chronic conditions and we want to know how are they doing within the telehealth, first of all, I don't think it's going to be, I live in the telehealth world and you live in the brick and mortar world. I do think optimally it's going to be integrated. I think that the quality measures ought to be the same, and we can probably compare the quality of telehealth visits to regular visits in terms of the technical

quality standards and so forth, but I think ultimately the measures need to be the same or you can't make comparisons. That's the general feeling. There was a strong conviction in the group also that telehealth should not be held to a higher standard than a brick and mortar care or in-person care, which I think nobody really disputed.

Ellen Kelsay:

That's a great point, and I think too, just as a little bit of a sidebar, it'll be interesting to see how providers and clinicians are trained in the future for virtual care delivery. That's not traditionally how most physicians and RNs and others in the field have been trained. So it does take a different skill set perhaps or different set of communication as well.

Peggy O'Kane:

Young people are going to be better at it; they're so used to communicating virtually anyway. I hope we're not depending on the medical schools to lead this because they have been kind of slow on a lot of different quality issues.

Ellen Kelsay:

They'll be one of the stakeholders that will hopefully have some shared learnings, as well, in this process. Also I wanted to ask you, shifting gears slightly, about the pandemics impact on the mental health crisis in this country and the needs certainly across all of society, as well as the underserved populations. In your mind, how do you think that the health care ecosystem needs to evolve to address the growing demand around mental health and emotional wellbeing?

Peggy O'Kane:

This is actually a bright spot that we talked about in our report. First of all, there was an increase in demand for mental health services, quite understandably given the trauma that people were experiencing. But there were all these companies out there with their remote behavioral health modalities, either through text or through video visits or telephone visits. They were all out there trying to get their foot in the door and all of a sudden people were able to access them. Many plans absolutely opened the door to that very quickly. My dream is that we hold them accountable for the outcomes and then we show the traditional behavioral health sector what their results are and say can you match this? It kind of turns the question upside down. Can it be as good? Or, if yours is better, why don't you prove it, let's see your outcomes. We've been doing work with people benchmarking depression outcomes. It's a small group of plans and organizations that are really interested in demonstrating how well they do this and learning from their own data. We think there's a tremendous opportunity to kind of push forward into what the context ought to be for quality in the future. What is it costing and what kind of outcomes were you able to achieve? I think it's an exciting moment and I hope we can take advantage of.

Ellen Kelsay:

I applaud your efforts there in raising the awareness and heightening the level of accountability.

Peggy O'Kane:

It couldn't be much worse than it was before. Behavioral health is just a national scandal, I think.

Ellen Kelsay:

It's so critically important that we make swift progress there, so great job on putting the light in a sorely needed area. Peggy, thank you so much for joining us in this very important conversation. Before we close to you have any parting words that you would like to share with our audience?

Peggy O'Kane:

Health equity, because of COVID and the shocking disproportionate number of deaths and prevalence of the illness among people of color, that was one thing. That was compounded by the George Floyd and Breonna Taylor incidents. Companies all over the country are now really trying to figure out what they need to do differently and I want to encourage the members of the Business Group to really embrace this issue. We need to learn together how we are going to correct these really unacceptable differences in outcomes. In quality improvement, what you do is you drill down and you figure out where the problems exist and you kind of experiment with different ways of getting to it. There really needs to be much more attention to these differences that we've been measuring and talking about for years, but haven't really closed. Your members need to ask their health plan partners for a real strategy with measurable differences in outcome, measurable closing of the gap based on color.

Ellen Kelsay:

You have really hit home such an important topic that I know has been very top of mind and front and center for our so many organizations and certainly our members. It is a significant issue that has long been ignored. You mentioned many issues earlier in our conversation related to the chronic disease burden or access to broadband or other services, and really not ignoring those issues any longer, asking the hard questions of health plans and other partners about their strategies to address, and even other solution providers, we talk about telehealth and all of the myriad virtual solution providers, how are they thinking about making sure that there's appropriate representation in terms of the providers that are put forth through their solution, but then also that their solutions and address those needs that you said. So I absolutely agree. I think that is again going to be a front and center topic for many, many of our members and hopefully all employers and their partners really in earnest work very hard to remedy those long standing issues. I'm really glad that you brought that up.

Peggy O'Kane:

Your mantra and our mantra ought to be show me the data and tell me what you're going to do about it, and then show me the results next time.

Ellen Kelsay:

All right. Show me the data; we'll mark that down.

Peggy, thank you again, always a pleasure. Thanks for joining us today.

Peggy O'Kane:

My pleasure. Thanks so much. Have a great day.

Ellen Kelsay:

Peggy O'Kane spoke to us from Silver Spring, Maryland. She is the founder and president of the National Committee for Quality Assurance which works towards improving health in the U.S. by focusing on quality, access, and equity. You can find the *Taskforce on Telehealth Policy Findings and Recommendations* report at the NCQA website, https://www.ncqa.org/.

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